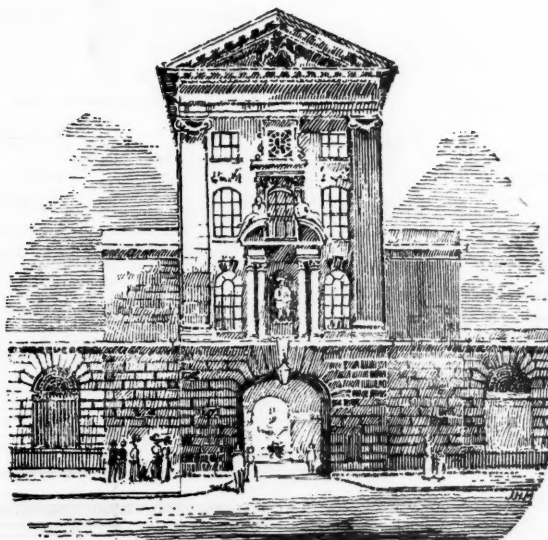


ST. BARTHOLOMEWS HOSPITAL JOURNAL



VOL. XXXIX.—No. 6.

MARCH, 1932.

[PRICE NINEPENCE.

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"Æquam memento rebus in arduis
Servare mentem."
—Horace, Book ii, Ode iii.

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CALENDAR.

Tues., Mar.	1.	—Dr. Gow and Mr. Girling Ball on duty.
Wed., "	2.	—Surgery: Clinical Lecture by Sir C. Gordon-Watson.
Fri., "	4.	—Medicine: Clinical Lecture by Sir Thomas Horder. Prof. Fraser and Prof. Gask on duty.
Sat., "	5.	—Rugby Match v. Rosslyn Park. Home. Hockey Match v. St. Lawrence College. Away.
Mon., "	7.	—Special Subjects: Clinical Lecture by Mr. Bedford Russell.
Tues., "	8.	—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.
Wed., "	9.	—Surgery: Clinical Lecture by Mr. Harold Wilson.
Fri., "	11.	—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
Sat., "	12.	—Rugby Match v. Moseley. Home.
Mon., "	14.	—Special Subjects: Clinical Lecture by Mr. Just.
Tues., "	15.	—Dr. C. M. Hinds Howell and Mr. Harold Wilson on duty.
Fri., "	18.	—Dr. Gow and Mr. Girling Ball on duty.
Sat., "	19.	— Last day for receiving matter for the April issue of the Journal. Rugby Match v. London Scottish. Home. Hockey Match v. Radlett. Away.
Tues., "	22.	—Prof. Fraser and Prof. Gask on duty.
Fri., "	25.	— Good Friday. Sir Percival Hartley and Mr. L. Bathe Rawling on duty.
Sun., "	27.	— Easter Day.
Tues., "	29.	—Rugby Match v. Bristol. Away. Sir Thomas Horder and Sir C. Gordon-Watson on duty.

EDITORIAL.

A FEW days before we went to press came the news of the death of Sir Frederick Andrewes. One of the great figures of the last generation, Sir Frederick devoted his life to the study of pathology and bacteriology and did much to make them what they are to-day—an invaluable adjunct to the science of medicine. None of our teachers was more beloved by his colleagues and pupils. His memory will be grateful to Bart.'s men all over the world. The news of his death did not come as a surprise; we all knew the nature of his illness, for he gave us a characteristic account of it, in an essay which is almost unique and which will

now become a "classic." To Lady Andrewes and her son and daughter we extend our respectful sympathy.

An appreciation of the great services of Sir Frederick Andrewes to St. Bartholomew's Hospital and College will appear in the next issue of the JOURNAL.

* * *

We learn that the recent economy campaign has already produced some results in the Dispensary, and that still better results are expected in the next few weeks. The outstanding item in the Dispensary bill appears to be liquid paraffin, of which 2500 gallons (10 tons) are dispensed annually at a cost of 5s. per gallon. It is stated on good authority that two teaspoonfuls will produce as good a result as two tablespoonfuls in the majority of patients. Other drugs, in the use of which economy can be effected are the proprietary remedies and products in which there is a "corner," such as bismuth and potassium iodide.

* * *

The new rule, long overdue, that insured persons cannot be seen without a letter from the panel doctor, except in cases of accident or emergency, has relieved us of some of the unnecessary part of our work. It is also recommended by the Economy Sub-Committee that the unnecessary attendance of out-patients should be discouraged, and that more patients be referred back to their panel doctors. *À propos* of this, we hope to publish shortly an agonized letter on the subject of "Chronics," written by one who has worked in the Surgery.

* * *

A most important document has reached us, in the form of the Final Report of the *Lancet* Commission on Nursing. It appears that we are faced with the prospect of a shortage of nurses in the near future. The reasons for this are only too obvious, and they are discussed

thoroughly and sympathetically in the report of the Commission, of which Prof. Fraser was a member. Nursing is surely the walk of life above all others in which the labourer is worthy of her hire; yet there are few vocations which ask for so much and give so little. Moderate reforms are outlined by the Commission, and it is to be hoped that they will be widely adopted, although the resources of most hospitals are already seriously strained. The report will be fully reviewed in our next issue.

* * *

Most Bart.'s men have sooner or later to decide an important question—what they will do when they leave the Hospital. The *Handbook for Recently Qualified Medical Practitioners*, of which the third edition has just been brought out by the British Medical Association at the moderate price of 3s. 6d., will help you to decide this matter. We are asked to draw attention also to Mr. Philip Mitchener's address, "After the Finals," which will be delivered at B.M.A. House at 5 p.m. on Tuesday, March 8th, and to which all recently qualified men are invited.

* * *

The long-awaited book on *Diseases of the Kidney*, by Mr. Girling Ball and Dr. Geoffrey Evans, has at last been launched upon the world. As is to be expected, this book maintains the great teaching traditions of the Hospital. Time does not yet permit of an adequate review, which will appear in the April issue of the JOURNAL.

* * *

The Fourth Annual Dinner of the Eleventh Decennial Club will be held at the Holborn Restaurant on Friday, April 15th. Dr. M. L. Maley will be in the Chair. Information may be obtained from the Secretaries, Wilfred Shaw and F. C. W. Capps, at St. Bartholomew's Hospital.

* * *

We tender our humble apologies to all who may have been misled or inconvenienced by our mistake in the "duties" for February as they appeared in the Calendar.

EXAMINATION HOWLERS.

I.

THE IMPORTANCE OF THE CONJUNCTIVE.

The question dealt with the symptoms of G.P.I., and the candidate was giving an example of the patient's grandiose ideas: "He often considers himself a person of great importance or the King of England."

OPENING REMARKS IN A DISCUSSION ON THE COMMON COLD.*

By SIR THOMAS HORDER, M.D., F.R.C.P.



R. President,—I appreciate greatly the compliment you pay me in asking me to open this discussion. I conceive your intention to be that a physician should present the subject in its general aspects, and that the more localized features of the disease which we term the "common cold," being concerned, as they are, with the nose, throat and ears, should be dealt with by members of the Section of the Society over which you preside. This being so, I propose to touch upon the more debatable general points of what, though it is perhaps the most frequent of all human ailments, is also one concerning the causation and prevention of which we know very little. That we cannot prevent the "common cold," or that we cannot nip it in the bud, is a favourite grievance of the general public against us. It behoves us to meet the charge frankly and scientifically, and I congratulate you upon your wisdom, and also upon your courage, in selecting this subject for to-day's discussion.

It seems desirable in the first instance to define our subject, so that we do not wander from it. And so I start by asking, What is the common cold?

We can often get nearer to a clear conception of what a thing *is* by marking off certain other things which it is *not*. "Paroxysmal rhinorrhœa" is not the common cold; nor is "paroxysmal sneezing"; nor is "hay-fever"; nor is "pituuitous bronchial catarrh"; nor is the acute naso-pharyngitis, with or without laryngitis and tracheo-bronchitis, which ushers in, or is incidental to, certain of the acute specific fevers, measles chief amongst them. Nor, probably, is "acute coryza," though here the differentiation becomes less clear, because the criteria, precise enough in the morbid states just mentioned, are not established with sufficient exactness. I speak always, and of course, of *our* criteria, not the criteria of the layman; indeed the layman has no criteria in these things, or he would not be a layman. To him any, or all, of these things are, or may be, inseparable from the common cold. If a fellow passenger in the train is seized with a paroxysm of sneezing, though it be purely vasomotor in nature, and non-infective, the timid layman shrinks away, and protects himself by an open window and his own handkerchief. His pathology is all wrong, but his actions are hygienically correct, for though the sneezing

* At the Section of Laryngology of the Royal Society of Medicine, February 5th, 1932.

person is probably not suffering from the common cold, even in its incipient form, he may be a carrier, and may convey, by the splashes from his mouth and nose, the virus of the disease to a more susceptible subject. It may even be that the bout of sneezing is of service to the sneezer, the flow of mucus actually clearing away infective material which has lodged upon the mucous membrane. It may be regarded as a special effort on the part of the defensive mechanism which we know to be present in the healthy nose. We have given up the use of sternutories in medical practice, and snuffing has gone out of fashion; we may have deprived our patients of some therapeutic benefit, even though they have gained in æsthetics by discarding an unsavoury habit.

So much for what the common cold is *not*. Let me now turn to what it *is*. I should define the common cold as "an acute specific catarrh, involving the upper respiratory tract, and in the great majority of cases chiefly the nose and pharynx, running a benign course of three to ten days, with pyrexia and certain constitutional symptoms, the attack protecting the patient against another infection for a short period only." Is the infection always the same? Or are there infective catarrhs, closely resembling each other, and yet due to different agents? I think this question is very analogous to the question, Is there one "influenza," or are there different "influenzas"? Though complete proof is not as yet forthcoming, it is probable that there is a true influenza, due to a filterable virus without (but generally with) secondary infection by catarrhal organisms, and a number of false influenzas, in which these catarrh-producing cocci and bacilli are present alone. So in acute naso-pharyngitis, it seems probable that what we generally understand by a "common cold" is a specific infection by a filterable virus, associated with secondary infection by catarrhal organisms readily isolated by ordinary bacteriological methods. There is probably, however, a number of other acute and very similar clinical conditions in which the infection is caused by these secondary invading organisms only. The terms, a "feverish cold," and "an influenzal cold," sufficiently indicate that these things are as here stated, and though these names are condemned by some writers, they are in fact justified by the inadequacy of our clinical differentia, and equally by the incompleteness of our bacteriological knowledge. A few years ago we were criticized severely if we diagnosed a case as influenza in the absence of the demonstration of Pfeiffer's bacillus. To-day, when the favourite view is that the causative organism of influenza is a filter-passer, such criticism has ceased. I have myself always inclined to a diagnosis of influenza

in proportion as skilled bacteriological examination of exudates failed to demonstrate any organism at all. And I take the same position in regard to an acute naso-pharyngitis—the cases in which the secretion shows few or no organisms in films, and little or no growth on ordinary laboratory media during the first twenty-four hours, are those which I regard as coming into the category of our discussion.

As to the *site* of the infection, although the disease is a simple rhinitis in the majority of cases—at any rate at first—the pharynx is often affected also, later if not earlier, and the larynx and the trachea not seldom. Some degree of sinusitis and of Eustachian catarrh, and also some degree of conjunctivitis, may be regarded as part of the type case, thus amply justifying the popular term a "cold in the head." It is interesting to note how frequently an individual tendency is shown in respect of the anatomical distribution of the catarrh. I think it highly probable that in some persons the nose nearly, or altogether, escapes, and the infection spends itself upon the pharynx, or larynx, or trachea. But this is not possible to prove in the present state of our criteria.

The intensity of the attack, and the degree of the constitutional disturbance, we know, again, to be very variable. In some persons the disease is prone to be quite trivial, in others quite devastating; and this, not only from the severity of the local discomforts, but also from the depth of the toxæmia. No doubt there are abortive attacks, and quite apart from the use of remedies. When we come to consider the question of the "*common cold*" in its chronic aspects, we are faced with so many difficulties that, quite frankly, I for one find them insurmountable. I am not sure that we have any facts to support the view that the causative agent of the acute rhinitis which we recognize as the "common cold" expresses itself in terms of a chronic catarrh. Of chronic nasal catarrhs we have plenty, but I think them to be different in origin from the catarrh of the "common cold," though some of them are doubtless sequelæ of one attack or, more probably, several attacks, of this disease.

Reverting, then, to the acute disease, the features of which we can easily recognize, I must express doubt concerning some of the *predisposing causes* often alleged, such as heredity and rheumatism. Age I am prepared to admit: as with most of the infections, increasing years bring a compensating immunity. We know there is a seasonal incidence in the disease, and that January, September and November are bad months for this and for catarrhal infections in general. Of *exciting causes* I doubt if we can admit mere cold, or mere heat, but rapid changes in temperature would seem to be a

definite adjuvant to what, all said and done, we must postulate as being the main causative factor—some *materies morbi* which, though proof is still to come, is probably of the nature of a filterable virus.

Our difficulties in differential diagnosis cannot, at present, be solved bacteriologically; still less can they be solved physiologically. The tissue which forms the nidus of infection is a mucous membrane. One of the functions of a mucous membrane is to secrete mucus; neither the snivelling nose of the urchin, nor the dripping nostril of the old man, necessarily connotes disease, still less any affinity with the "common cold." They may only mean that there is a departure from the ideal healthy mucosa on the one hand, and the presence of irritants, mechanical or chemical, in the atmosphere of the other. The nearest solution we possess at present to this diagnostic problem is a careful clinical study of the case, and experience of many other similar and dissimilar cases. Though this statement is not popular these days, when clinical observation has become the Cinderella of medicine, I believe it to be true, as I believe it to be true of influenza, of measles, of encephalitis, and (though I am here speaking prophetically rather than scientifically) of all infections in which the causative agent is of the filterable virus type.

Let me now turn to some points that need discussion on the subject of *treatment*. I will touch upon preventive methods first and curative methods afterwards. *Prophylaxis* in regard to the common cold is a subject of great importance. Consideration of this falls under five heads: general measures as regards the individual, whereby his susceptibility is lowered; purification of the atmosphere, and especially of public buildings and living-rooms, thus lessening the risk of infection; cleansing and disinfection of the nasopharynx; isolation of the infected person; and preventive inoculation.

(i) It is generally assumed that the fitter the individual, the less prone is he to fall a victim to the common cold; that "hardness" tends to resistance, and that "softness" tends to susceptibility. I am not sure that this belief, which we and the public share in common, will stand the test of strict inquiry. It is a common experience that the fitness we store up during a holiday does not save us from experiencing an attack of the disease when we return to work; indeed, we seem to be specially prone to the infection during the first few days after we resume duty. This recalls the experience of fever hospital practice, where the resident officers are more likely to develop scarlet fever during the first week or so of their return from a holiday than at other times. It is good to have an A1 population,

and I have nothing to say against the exhortations to personal hygiene in the matter of clothes, food, exercise and ventilation which we read under the heading of "preventive treatment" of this disease in some of the text-books. But I am not convinced that the "common cold" is, like tuberculosis, a disease "of low resistance," though it is clearly often regarded in this light. We must not confuse a tendency to infection with ability to stand the disease. It is very easy to let our ideas get in advance of our facts. If we consider only the primary infection, then I think experience shows that fitness does not necessarily protect us against it; but I also think that it fares worse with the weakly and with the tired patient in respect of the secondary infections than it does with the patient who is fit at the time he becomes infected. Once more the analogy with influenza seems very close: during epidemics, many of the very severe, and even fatal, cases of the primary infection occur in robust young adults; but debilitated patients succumb more frequently to streptococcal and other infections of a secondary nature.

(ii) That the avoidance of over-heated and vitiated atmospheres tends to diminish the frequency of infection may be conceded, but whether this is due to a beneficial effect upon the patient's health or to a lessening of the contact risk is uncertain. An obvious fallacy of the same kind underlies the argument of the fresh-air and the cold-bath enthusiast. These things may not act so much by raising resistance as by diluting the virus.

Can anything be done by way of systematic spraying of the atmosphere, furniture, etc. in schools and other institutions? Dr. C. J. Wells has recently reported favourably concerning the use of a 10% formalin spray in a boarding school under his care. (See *Brit. Med. Journ.*, Jan. 9, 1932.)

(iii) Of local measures of defence there are two that may be referred to: (a) I assume a unanimity in favour of correcting defects in the air-way of the nose and pharynx, of relieving obstruction, of draining areas of focal sepsis, and of treating chronic catarrh, seeing that chronic catarrh predisposes to acute catarrh—though here, again, not all acute catarrhs arising in such patients are examples of the "common cold": many are entirely of endogenous origin. I also assume that we believe in teaching and exhorting physiological breathing if this is not being observed. These matters will no doubt be dealt with by some of those who follow me. (b) Does any form of treatment of the mucosa of the nose and throat lower the susceptibility to infection, and, if so, what method is the most helpful? Should it be simple cleansing, as by an isotonic salt solution?

If so, what is the best technique: is it by spray or by douche? Or is an antiseptic of greater value; and if so, which? Should we aim at some degree of penetration by the chemical agent, or be satisfied with a purely surface application? I think these matters can also best be dealt with by those who have an intimate acquaintance with the mucous membrane concerned. Here, too, there may be statistical evidence available, whether from school doctors or others. Be it remembered, however, that without appropriate controls all statistics of this kind are unhelpful.

(iv) Isolation of the infected patient is a principle which the public has accepted. Unfortunately the mild case, which is equally contagious with the severe one, goes free, and on economic grounds this can scarcely be avoided.

(v) A great deal of preventive treatment has been attempted by means of antigens of the type of bacterial vaccines. Dr. Freeman will, of course deal with this matter. If we have not as yet isolated the infecting agent, it is obvious that all our present efforts can only deal with the secondary infections—valuable remedial measures, no doubt, but scarcely touching the root of the matter of the common cold *in excelsis*. Some of our patients who have been inoculated ask for more, and thus emphasize their conviction that they have been helped. Others are disappointed. A few declare that vaccines have increased, rather than lessened, their liability to the infection. The number, and variability, of the different formulæ used bespeak our ignorance of which is the most efficient. No doubt efficiency varies with the particular catarrh endemic at the time, and also with the individual. We do not seem to have decided whether the most effective vaccine should be of the "stock" or of the "autogenous" kind. It may well be that this uncertainty is bound up with the question whether a patient's recurrent catarrh is exogenous or endogenous in nature. If exogenous, the stock vaccine is likely to be more helpful to him; if endogenous, the vaccine prepared from the flora of the patient's own mucosa is more likely to give protection.

Curative treatment should begin at the very earliest moment. Time, the essence of most contracts, is specially essential here. I regard our ability to "abort" an attack of the common cold—though by no means in all instances—as an established therapeutic fact. Nor are the remedies either specific or magical. Many of them are old wives' cures, but by no means to be despised on that account. I believe in the hot bath,

in copious hot drinks, in a smart purge, and in a warm bed. I believe in opium. But I do not think it matters greatly if the subsequent remedy be cinnamon, or aspirin, or ammoniated quinine, or camphor or any other of the numerous "panaceas"; and the patient's faith in the remedy must by no means be scouted. I am dubious about the value of local measures, though I am sure they give comfort, and I think the essential oils, in addition, help to protect the other parts of the U.R.T. But I am here to learn about local measures from my rhinological colleagues. As the disease progresses, treatment of the patient becomes more and more important, and treatment of his nose less and less so, though we have to remember that the adnexa, whether the sinuses or the larynx and trachea, frequently require attention. Treatment during the stage of convalescence does not call for discussion.

But I must digress a little in view of some recent developments in therapeutics in acute infections in general. It has formerly been the custom to speak of remedial measures of a curative kind as specific and non-specific. The whole principle of the specificity of remedies in infective diseases has lately been called in question. I have made some reference to this matter in my Presidential Address to the Harveian Society last month. The practitioner's post-bag is to-day crowded with literature concerning a number of substances which he is invited to use in the treatment of several acute infections which certainly own a very different ætiology. The common cold shares this invitation with influenza, pneumonia, furunculosis and streptococcal septicæmia. And there seems no reason why the list should not be extended to include typhoid fever, encephalitis, and psittacosis. I refer, of course, to S.U.P., edwenil, antibacyn, *et hoc genus omne*. Time alone can decide if this class of remedy is really helpful in combating acute microbic infections, and to what extent. The history of therapeutics records the introduction of not a few empirical measures which have been subsequently rationalized, so it ill behoves us to condemn these substances out of hand. Rather is it our duty to preserve a healthy scepticism in observing their effects. Our other duty, or rather the duty of those who press these remedies upon the profession, and therefore upon the public, is to pursue such lines of research as will test the hypothesis upon which their action is based. I have no personal experience of these remedies to offer this evening, but it may be that others present have used them, and will tell us what results they have had in the treatment of the "common cold" by means of them. It would not be without precedent if we succeeded in finding a potent remedy for this troublesome complaint on chemo-therapeutic lines, even

before we know with certainty the nature of the infection, and thus pave the way for treatment of an immunological kind. Be the method one of chemo-therapy or of immunotherapy, we shall welcome the defeat of the common cold as being the defeat of a common enemy.

CLASSIFICATION IN THE STUDY OF MEDICINE, WITH SPECIAL REFERENCE TO NEPHRITIS.

THE student beginning the study of medicine is no stranger to classifications. The first one he meets is a lengthy one, beginning, 1, Protozoa, 2, Metazoa, and passing vertebrates and invertebrates, it arrives finally at "man," and is designed to show the insignificant place he holds in the scheme of life. This, and others that he meets until the beginning of his clinical work, are classifications of unassailable value. They are definite *ex cathedra* statements, and as such are not to be doubted, merely accepted. On beginning his clinical work, however, the student finds that a classification is taken down from that lofty position. Soon the timid student is making, or is being asked to make, classifications of his own.

From an inspection of many of the authoritative classifications now extant, it will clearly come as a surprise to many that classification is a branch of logic with rules of its own. The errors of the many, then, make it necessary to inquire into—

1. The object of classification.
2. The rules of classification.
3. The practical use of classification.

This inquiry proved open to attack in two ways: by questioning people who knew, or spoke as if they knew, what a classification was and why, and by reading books on the subject. The books were very helpful.

Thus: "Classification is the collecting under a common name of a number of objects which are alike in one or more respects. The process consists in observing the objects, and abstracting from their various qualities that characteristic which they have in common."

Again, elsewhere: "Classification consists in discovering the causal relationships of natural objects."

The first statement deals with the grouping of the various symptom-complexes under a single head; for example, the collecting of the various diseases included in the term "nephritis." The second definition is more helpful, and if the phrase "natural objects" is allowed

to be paradoxically applied to disease, and the disentangling of the various entities contained within the groups is carried out with that definition in view, the classification evolved will be both accurate and useful. The logical classification based on the second definition would be an ætiological one, which, as the writers on the other side of the Atlantic have pointed out, is also the most useful form a classification can take from the clinical point of view.

The "rules of classification" were, on investigation, an unknown, unwanted quantity to the large majority of people using and making classifications. Books, on the other hand, yielded an awe-inspiring list, grandiloquently called "The Canons of Classification," beginning with one which reads: "A classification should proceed from terms of great extension and small intension to terms of small extension and great intension." This merely means that a classification should proceed from a term of general application, such as "nephritis," to terms of ultimate particularity, such as "acute embolic focal nephritis."

Aggressive as these canons were, they had much sense and are worth repeating. Apart from the one already quoted and paraphrased, they are:

2. The process of division must be gradual.
3. The basis of the classification must be essential to the purpose.
4. The characteristics must be consistent.
5. The terms must be mutually exclusive.
6. The enumeration must be exhaustive.

The terms are self-explanatory, and when written seem obvious, but how many classifications follow them? To take the classification written below and examine it, in order, by the light of the canons, will show how an apparently sound classification flings them over the windmill and runs wild on its own account.

NEPHRITIS.

1. Acute diffuse nephritis.
2. Chronic parenchymatous nephritis.
3. Chronic interstitial nephritis.
 - A. Primary granular kidney.
 - B. Contracted white kidney.
4. Trench nephritis.
5. Renal syphilis.

Canon 1.—The term "nephritis" is certainly one of great extension, but hardly can the term "acute diffuse nephritis" be said to be one of "great intension and small extension," including, as it does, all forms of acute nephritis (except "trench nephritis"), with such widely differing conditions as "embolic focal nephritis" and "acute glomerulo-tubular nephritis."

Canon 2.—To jump from the term "nephritis" to the term "renal syphilis" cannot by any stretch of the imagination be called "a gradual process of division"

Canon 3.—This is controversial. Presumably the person who made the classification found it essential to the purpose, but it will be found that a classification which is more generally logical will be more useful in practice.

Canon 4.—The basis of division is very far from consistent. Terms 1, 2 and 3 are divided from the general term "nephritis" on a basis of morbid anatomy; the terms A and B from the term "chronic interstitial nephritis" on a basis of the post-mortem appearance; 4 and 5 on an ætiological basis in respect of environment and in respect of bacteriology respectively.

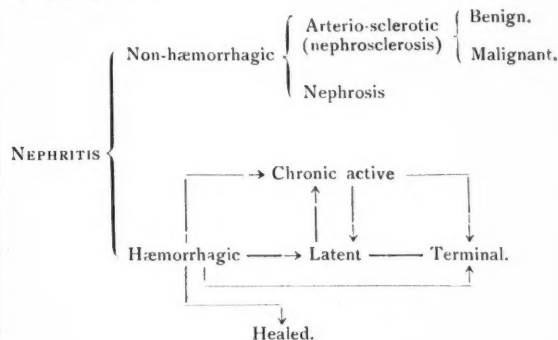
Canon 5.—As has already been shown in connection with Canon 1, the terms "trench nephritis" and "acute diffuse nephritis" do not mutually exclude one another. It may be mentioned, in passing, that this is the commonest fault of the classifications which are met with in connection with medical work, and leads to a great deal of unnecessary repetition.

Canon 6.—The classification makes no mention of "tuberculous nephritis," to mention only one omission, but here it may be said in excuse that the classification was not meant to be a complete one, merely one for some particular use.

From this it can be seen the chief trouble is with the terms employed, and that provided the terms are well chosen, the classification itself will be almost self-made. In fact, to return to the definitions, when it is settled what the "natural objects" are, the rest is easy—in medicine, at all events, since it does not deal with lengthy lists which would present any sort of problem to the expert classifier.

Classifications are so universal that the replies to the third question, namely, What is the use of classification? should have been clear and unequivocal. The result was, however, a large and diverse opinion, which showed that classifications may be varied to suit their purpose with advantage. In fact it became clear that a pure, correct classification was not to be preferred to one that was more useful in practice, even if the latter showed some of the "faults" already pointed out. Be that as it may, the main purpose of medicine (though this is somewhat controversial ground) is first to prevent disease, and secondly, to cure and alleviate it, and the classification which assists the practical side of the practice of medicine will not only be the most commonly met with, but also the most useful. A classification for this latter purpose, then, will be one which will assist the physician to visualize the morbid process, and its cause, by which the patient is incapacitated, and enable him

most easily to recall those appropriate remedies which are available. A classification which has this point in mind is the one which includes the terms "azotæmic" and "hydræmic" in its nomenclature. And more recently in a scheme of Van Slyke's, given in simplified form below.



This is scarcely a classification, and as such is not really a fair game in an article of this type, but it contains a piece of erroneous thinking to which attention should be drawn. The whole point of such a scheme is that a clear clinical distinction is made between the "inflammatory" and "vascular" forms of nephritis, the clue to their division being the fact that in the "inflammatory" form there will always be some degree of hæmaturia, however slight. This is perfectly correct, though it is well known that in the old "chronic inflammatory" forms the blood is often small in quantity, and numerous examinations of the centrifuge deposit may be necessary before that blood is found, but if a case of the "vascular" type is admitted to hospital the correct diagnosis will never be made during life, since (apart from extra renal blood, which may place the patient in the wrong class altogether), the laws of medicine (and logic) do not allow an affirmative inference of any kind—universal or particular—to be deduced from a particular negative proposition. Thus the denial of hæmaturia (the particular negative) will never allow of a diagnosis of "vascular" nephritis (the particular affirmative).

Constructive criticism being of more value than destructive, the building up of a comparatively elaborate classification will be shown in detail, the same subject (nephritis) being retained.

As already indicated, the terms are the main difficulty. The definition of those terms must, therefore, be the first task.

The word "nephritis," coming from the Greek νεφρίτης, meaning "pertaining to the kidneys," has a classical correctitude about it, but in its modern sense the word cannot escape so easily, since the termination

"itis" has for some time been held to indicate inflammatory processes, and two at least of the conditions included under the term "nephritis" are not inflammatory in nature. However, the term has been hallowed by custom, and it would be useless to try and change it. The term "nephritis" is taken, then, to mean that series of disorders attributable to pathological processes causing dysfunction of the kidney in part or whole, or to diseases in the blood-vessels thereof. This gives a fair view of the extension of the term, without trying to give any bullet-proof definition.

The more intensive terms are chiefly conspicuous by their multiplicity, and the possibility is that the name applied by one person does not refer to the same symptom-complex as is referred to by another who uses a so-called synonym. To make the matter quite clear, "acute Bright's disease," "acute catarrhal nephritis," "acute glomerulo-tubular nephritis," "trench nephritis," (even) "acute diffuse nephritis" are all names applied to more or less the same condition. More or less; but how much less? The point is of some importance, and in formulating a classification it will be necessary to give a short explanation of some of the terms used.

The first division of the classification is into the inflammatory and "vascular" groups, the term "non-inflammatory" being preferred to "vascular." The inflammatory group is subdivided into suppurative and non-suppurative classes, and both main parts are yet further divided into the clinical types "acute, subacute and chronic"; there is, however, no advantage gained by so dividing the vascular group. Thus far the divisions are:—

NEPHRITIS.

1. Non-inflammatory.
2. Inflammatory:
 - (a) Suppurative:
 1. Acute.
 2. Chronic.
 - (b) Non-suppurative:
 1. Acute.
 2. Subacute.
 3. Chronic.

The non-inflammatory group finds its final divisions on an ætiological basis, the terms "primary vascular nephritis" and "senile nephritis" being the most definite that the present state of knowledge allows. The increase in knowledge which is reasonably expected, and which will throw more and more light on the ætiology (and therefore on the correct classification), adds to the already difficult task, but if the classification aims at placing the terms of known ætiology in their correct positions, and then adds the terms of unknown

or hypothetical ætiology in their *probable* places, then, so far as they have been correctly placed, by so much the less will the whole classification have to be altered with every new discovery. With nephritis there is enough known already to build such a skeleton scheme, but in conditions such as enlargement of the thyroid, so little is known that the best classification is still entirely a pathological one. Although, therefore, it is not a fully established fact that "vascular" nephritis, as it is termed here, is really due to vascular disease, as opposed to primary inflammation of the kidney, it is taken as the more likely cause, and some definite opinion must be taken on controversial matters, or the whole classification becomes a thing of straw.

In the inflammatory section, taking the suppurative subsection first, the final divisions might quite easily be made on a bacteriological basis, but to subdivide the suppurative pyelo-nephritises into the large number of classes such a procedure would involve would be an act of folly, and here distinction has only been made where the treatment differs so much that it calls for special remark, the two conditions being "syphilitic interstitial nephritis" (occurring in the tertiary stage, and may be conveniently held to include the rare gumma of the kidney), and "tuberculous pyelo-nephritis." The term "suppurative pyelo-nephritis" (*sic*) is to be taken in this classification to mean all suppurative conditions except those due to the *Sp. pallida* and the tubercle bacillus.

The non-suppurative inflammatory group has three subdivisions, acute, subacute and chronic, of which the two last have, each, only one final term, whereas the acute group is here divided into four subgroups, and if some people had their way, apparently, it would not fall far short of a dozen. The mass of nomenclature provided for this group is prodigious, and it has been deemed churlish to refuse the work which so many clever brains have done in constructing more and more complex terms, and though they cannot all be used, there have been introduced no new terms with the possible exception of the term "pan-nephritis" (or should it be "*πασανεφριτις*" since "*νεφριτις*" is feminine?). The first term in this group, "glomerulo-tubular nephritis," is the common condition known to all, showing œdema, hæmaturia, sore throat and albuminuria. "Tubular nephritis" is the condition associated with toxæmias generally, notably eclampsia. The tubules only are damaged, and it might be held that since the division here is on an histological basis (except in respect of the last term), there ought also to be a class for a pure "glomerulitis," and, indeed, such a class was suggested by some American writers, but it is doubtful if such a condition ever exists

owing to the interdependence of the tubules on the glomeruli, which ensures that if the glomeruli are damaged the tubules also will suffer, but the tubules may easily be damaged without the glomeruli being hit. The term "acute interstitial nephritis" is used to designate different conditions by different people. A member of the staff states categorically that not only does it occur very rarely (in the *first* week of scarlet fever), but also that it is invariably fatal. Muir, on the other hand, states that it probably occurs more often than is suspected, and "is never fatal." He probably refers to the common albuminuria of acute fevers, and in this classification the term is used in the sense first mentioned, viz. the fatal, scarlatinal form. The "syphilitic pan-nephritis" is the condition occurring in the early secondary stage, giving a massive cloud of albumen, most alarming (one can imagine) to the inexperienced, but which clears up very rapidly under anti-syphilitic treatment if it is remembered that mercury is contra-indicated. "Trench nephritis" has been blessed with a name of its own, but for no adequate reason, since the cases occurring during the Great War are appearing at the post-mortem table just as the other old, acute, glomerulo-tubular forms do, and there is nothing very remarkable in their mode of onset, except that the patients have been exposed in a trench rather than to some more pacific form of cold and wet.

The two terms in the subacute and chronic classes have caused more difficulty, almost, than all the other forms, owing to the terms "parenchymatous" applied to the "subacute glomerulo-tubular" form, and "chronic interstitial nephritis" applied to the "chronic pan-nephritis." These terms were originally devised with the idea of indicating that in the subacute stage the main symptoms were still due to the lesions in the glomeruli and tubules, whereas in the chronic stage the fibrosis and scarring of the interstitial tissue dominated the picture. The term "pan-nephritis" is suggested with exactly the opposite idea, namely, of indicating that the lesions in the glomeruli and tubules are still active, but that the scarring process, before mentioned, has been superadded. This class is now set out as follows:

ACUTE, NON-SUPPURATIVE NEPHRITIS.

1. Embolic focal nephritis.
2. Glomerulo-tubular nephritis.
3. Tubular nephritis.
4. Interstitial nephritis.
5. Syphilitic pan-nephritis.

And the whole scheme:

NEPHRITIS.

1. Non-inflammatory.
2. Inflammatory.

Non-inflammatory:

- A. Primary vascular nephritis.
- B. Senile nephritis.

Inflammatory:

- A. Suppurative.
- B. Non-suppurative.

Suppurative:

1. a. Acute suppurative pyelo-nephritis.
- b. Embolic focal nephritis.
2. Chronic.
- a. Chronic suppurative pyelo-nephritis.
- b. Syphilitic interstitial nephritis.
- c. Tuberculous pyelo-nephritis.

Non-suppurative:

1. Acute.
2. Subacute.
3. Chronic.

Acute:

- a. Glomerulo-tubular nephritis.
- b. Tubular nephritis.
- c. Interstitial nephritis.
- d. Syphilitic pan-nephritis.

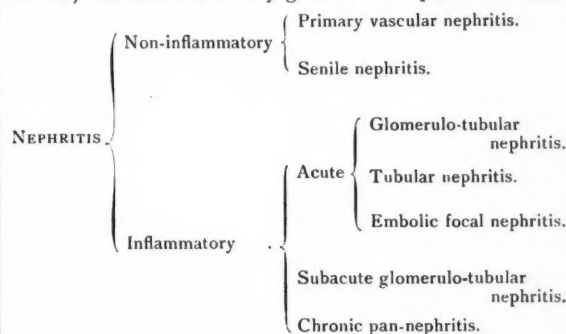
Subacute:

Subacute glomerulo-tubular nephritis.

Chronic:

Chronic pan-nephritis.

This is far too complex a scheme to carry in the head for ordinary purposes, and is not intended as such. A smaller scheme, including the common conditions, is added; the above is merely given for completeness sake.



This classification is almost identical with that recommended by the authority mentioned in connection with "acute interstitial nephritis," whom, it may be said, many students must thank for being the first person to throw that revealing ray of light into the darkness which surrounds their conception of nephritis. This last classification, be it observed, has the great merit of brevity, and in making other classifications it is well to remember that "Nature is pleased with simplicity, and affects not the pomp of superfluous clauses."

BARON RUSSELL.

RUPTURE OF A DISSECTING ANEURYSM OF THE AORTA.

THE following case is recorded not only because of the rarity of the condition, but also on account of the difficulty in ante-mortem diagnosis, in spite of the fairly classical sequence of events, which may so easily be followed when the solution is before us.

G. B—, a well-built man, æt. 50, publican by trade, was admitted to St. Bartholomew's Hospital on December 8th in a state of coma.

It was stated that he had had kidney trouble twenty-five years previously, but had completely recovered. *Six years ago* he had some pain in the back and passed red urine, and an X-ray diagnosis of calculus was made. No operation was performed. *Four months ago* he began to feel "off colour" and lost his appetite, but had no headaches or vomiting. *Two months ago*, as the result of an attack of bronchitis, he went to see his doctor, who diagnosed kidney trouble, and for the last *three weeks* he had been kept in bed. During this period of rest he had felt much better, but had had attacks of mistiness of vision. On the morning of the *day of admission* he was seen by his doctor, who said that he could get up later in the day. He had a light lunch at 1 o'clock, and at 2.30 a severe headache suddenly began. His speech became wandering, while he stared vacantly about the room. His left arm began twitching, and this gave place to generalized convulsions, which lasted for ten minutes. He then sank into coma with stertorous breathing, from which he was slowly recovering when seen in the Surgery at 5 p.m.

He had always been a healthy man and came of good stock, but was passed B1 in the army. He had had no symptoms of cardio-vascular failure except shortness of breath on exertion, and he had never had any præcordial pain. There was no difficulty or increased frequency of micturition, but he was slightly puffy under the eyes in the morning. He had had a slight cough for three weeks.

When seen in the Surgery he was drowsy, but could be roused. There were no signs of trauma. The right pupil was smaller than the left and reacted less briskly to light. The fundi and discs were natural. No abnormality in the cranial nerves, other than the change in the pupils, was discovered except slight weakness of the left face. There was no change in power or tone in the arms or legs, but the patient complained of slight numbness of the left hand. There was no sensory change and the reflexes were natural.

The tongue was covered with a moist brown fur.

The veins of the neck were prominent. No abnormality was found in the lungs. The cardiac impulse was heaving, the apex-beat being $1\frac{1}{2}$ in. outside the mid-clavicular line in the fifth space. The aortic second sound was loud and prolonged, but there was no murmur. Pulse regular, rate 95, arteries hardened and tortuous. Blood-pressure 180/140. The urine was pale, clear, with a moderate cloud on boiling and a slight red deposit with Benedict's reagent, but no acetone was present. Nothing else of note was discovered on examination of the patient.

The next morning he appeared better, but at 6 p.m. he had a sudden attack of pain under the sternum, radiating to the back between the shoulder-blades. This pain caused him to writhe in bed, but the pulse-rate and blood-pressure remained unaffected. The pain recurred with intermissions and at times he became quite irrational, but could temporarily be roused and would converse naturally. At one time during the night he tried to throttle the nurse, and later attempted to kiss the "Houseman," but the latter escaped, and the unwanted blessing was bestowed on the porter who was now looking after him.

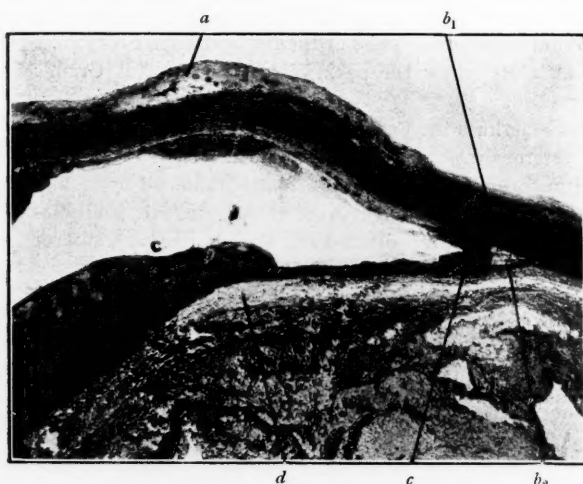
The following day it was discovered that there was diminished movement, impaired percussion note and weak breath sounds at the left base of the lungs. The signs were so obvious that the unhappy house physician began to think it was time that he gave up medicine and took to marbles if he had missed them on his routine examination thirty-six hours before.

The diagnosis at this stage seemed most obscure. Was the condition due to a cerebro-vascular accident consequent upon a renal hyperpiesis? Or, was the patient uræmic? The high diastolic blood-pressure coupled with the history and the albuminuria was suggestive. The glycosuria seemed obviously due only to arterial change in the pancreas, or possibly it might be cerebral in origin, but at all events it was not of ætiological significance. Did alcoholism play any part in the mental state, as the patient's occupation might suggest? There were no stigmata of spirochætal infection of the nervous system. Then what about the pain and signs in the chest? Coronary thrombosis seemed an unlikely cause of the pains, as the pulse-rate and blood-pressure were unaffected, and there was an absence of change in the cardiac signs. Could hæmorrhage into a neoplasm cause such signs and symptoms? Such were the thoughts that passed through one's mind, when, to complicate things further, the report on a lump of blood-clot which the patient had expectorated came back stating that tubercle bacilli were present. This statement was received with some scepticism. The blood-urea was determined and found to be only

65 and 68 mgrm. per cent. on two occasions, and the blood-sugar was 155 mgrm. per cent.

The condition of the patient remained the same, attacks of pain in the chest, which necessitated the exhibition of morphia for their control, continuing until the fourth morning after his admission, when he was sitting up in bed talking to his wife, and, without a word, fell back dead.

At autopsy there was atheroma of the basilar artery, a small thrombus in the middle cerebral artery, with softening of the anterior part of the lenticular nucleus on that side. The mediastinum was infiltrated with blood-clot, in which the œsophagus was embedded.



TRANSVERSE SECTION OF THORACIC AORTA, SHOWING EDGE OF DISSECTING ANEURYSM. *a*, ATHEROMATOUS INTIMA. *b₁* AND *b₂*, MEDIA SPLIT BY DISSECTING ANEURYSM. *c*, BLOOD-CLOT. *d*, ADVENTITIA.

The left pleural cavity contained a massive blood-clot and the left lung was collapsed. The right lung was emphysematous and the pleura natural. The whole aorta, from the second part downwards, showed atheroma but little calcification. A dissecting aneurysm was found, with the initial tear of the intima and media situated at the level of the diaphragm and involving the whole circumference of the vessel. From this point the splitting of the media had extended both upwards and downwards throughout the length of the thoracic and abdominal aorta, and even into the common iliac arteries. The section shows the splitting of the media near to the adventitia, the cleft being occupied by blood-clot. The kidneys showed arterio-sclerotic changes, but not in a very marked degree, and the rest of the viscera were normal for the man's age.

On reviewing the events in this case, the sequence seems to be as follows: The patient suffered from arterio-sclerotic changes in the aorta, kidneys, pancreas and cerebral vessels. An embolus was dislodged probably from the aorta and caused a cerebro-vascular disturbance. An embolus in a branch of the middle cerebral artery could cause softening in the region of the anterior part of the lenticular nucleus, and this might be expected to give the same symptoms as those of the patient, namely clonic movements and possibly some motor or subjective sensory change, but these signs and symptoms should be contra-lateral. In this case, so far as records go, they were homo-lateral. While in hospital the leak into the mediastinum from the dissecting aneurysm, which had resulted from the diseased condition of the wall of the aorta, began. This gave rise to the pain and the physical signs in the left chest by pressure on the root of the lung. Instantaneous death occurred on rupture of the aneurysm into the left pleural cavity.

According to Boyd, dissecting aneurysm is confined to the aorta, and only occurs after the age of fifty. In the senile aorta there is atrophy of the oblique elastic tissue of the media, and hence when a crack, the result of atheromatous degeneration, occurs in the intima, the media is easily split into two layers. The blood "dissects" its way through the media, extending both longitudinally and around the circumference. The blood may rupture back into the lumen at another point, or the clot may become organized, contract, and leave a space in the media. More often, however, an external rupture occurs, causing death within a few days of the initial symptoms, which are, as a rule, by no means pathognomonic. In 121 case-reports examined by Wood, pain in the back was mentioned in 19, but this pain appeared to have no localizing value for the site of the rent in the wall. The only two other symptoms he mentions were bradycardia, which occurred only in 5 cases, and tingling or pain in the legs. In the majority of the cases death occurred so rapidly that inadequate histories were obtained.

I should like to express my thanks to Prof. Fraser for allowing me to publish the notes of the case, and to Miss Vaughan for photographing the section.

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G. D. KERSLEY.

POUPART AND ALL THAT: A MEMORABLE ANATOMY.

COMPRISING ALL THE FACTS YOU CAN REMEMBER AND ALL THE RELATIONS YOU CAN RECOGNIZE, INCLUDING SEVENTY-NINE *GOOD THINGS* AND SEVENTEEN CAUSES OF SURGEONS.

By I. BRAY, L.S.S.A. (*failed*).

CHAP. IX.

THE ABDOMEN.

We now come to the most exciting part of anatomy. The abdomen is lined throughout and throughin by a serious membrane called the perineum. Sometimes it is so serious that only a demonstrator can follow it. The perineum divides the abdomen into two sacks, known as the greater sack and the lesser sack. The greater sack holds the most usually, but, with the exception of the headovthe pancreas, all the abdominal viscera have been known to enter the lesser sack. The student should verify this observation on himself and his friends.

The entrance to the lesser sack is through a piccolo foramen, socalled because at this point there is a rift in the flute. It might have been called the foramen ovale or foramen rotundum, both of which would have done very nicely, but these names had already been bagged by the skull. So it was given the nickname Foramen of Winslow, after an anatomist who didn't get the windup on the morning of the primary fellowship.

THE LIVER.

The liver lies in the upper part of the abdominal cavity with its upper convex surface applied to the dome-like diaphragm. It is thus TOP ORGAN which is a *GOOD THING*. The liver is quite a fashionable organ; even "Ladies" have them and they are specially developed in retired Colonels.

The liver shows—

- (a) A wave of fossæ—for bladders, veins, etc.
- (b) A wave of ligaments.
- (c) A beyeraria.
- (d) A Spigelian lobe,
- (e) A wave of ducts.

Associated with the liver is the gall bladder, which is one of the causes of surgeons. The gall bladder is not seen in the vertical disposition of the perineum, because it PEEPS from behind the tip of the ninth costal cartilage (Lady Godiva is sometimes represented in the abdomen by a teratoma of the ovary, the layer of rods and cones being shrouded demurely by a wisp of chestnut hair).

THE STOMACH.

The most memorable thing about the stomach is that it is all wrong. The only way truly to appreciate its shape is to look at it with X rays when it will be seen to be full of J's fluid except for the bubble at the top. The stomach has waves of curvatures and surfaces, and beyond is the duodenal cap. The duodenum usually refuses the customary gesture of politeness, even to ladies, as Part I and Part II are so occupied in embracing the headovthe pancreas. This is the main function of the duodenum.

After Duodenum Part III the intestines get involved in a series of Convocations. The student's best plan is to walk quietly down to the R.I.F. and look for its terminal part there. Another way is to get a pack of typhoid baccilli and hiss at them "Seekum! Seekum!" and then follow the pack. This is known as Gram's method.

Sometimes the Convocations get enraged by violence, overcrowding and claustrophobia. Then the Grey Tomentum slowly proceeds to the inflamed area, and the intestines indulge in diatribes, dialysis and diapidesis, and even diarrhœa. This is another cause of Surgeons and is therefore a *Good Thing*.

The Seekum, although blind, generally manages to find the appendix unless some bold surgeon has already removed it. Sometimes it has to search behind the perineum, psoas to make sure the ubiquitous organ is not hiding there. Having found the appendix, the seekum anchors it by means of a memorable vascular fold known as "The bloody fold of Treeves."

The most utterly memorable structure in the abdomen is Meckel's diverticulum, which was first discovered, post mortem, by Meckel, in himself. Lying back against the wall of his cave he thus apostrophised his discovery—

Methinks thou art a viscus ne'er described
And I, expiring, do expound on thee!

HERNIA.

While in the inguinal region the student should again examine the anatomy of hernia. Hernia is the chief cause of Surgeons, and is thus a *GOOD THING*. These are three kinds of hernia, inguinal, femoral and funny. The funny ones are rare but memorable and include—(i) obdurate, (ii) die a phlegmatic.

THE BLADDER.

The bladder is less memorable in the female than in the male, due to overcrowding. The nerve supply is from two sources, the sympathetic and the unsympathetic. This explains nocturnal enuresis. At the base of the bladder is found the prostrate gland, so

called because it gets you down in advancing age. It is roughly the size and shape of a horse-chestnut. [N.B.—Most memorable things in anatomy are roughly, especially the crista galli and the deep muscles of the back.]

THE KIDNEYS.

The kidneys are paired organs, placed behind the perineum, and were first discovered by Morrison who was hit there in a boxing match. This was a GOOD THING as it caused more surgeons and explains the buttons on a tail-coat. Crowning the kidney is the supra-regal body which raises the B.P. and is the ONLY cause of physicians. This is a doubtful thing.

THE SPLEEN.

Incredible as it may appear, the spleen was found present in 100% of autopses conducted by P. Bland and in 100% of dissecting room subjects injected by Hallet (1928). Such remarkable unanimity among anatomists suggests dirty work at the cross roads. The best spleens are very suitable dissecting room missiles, and certain German writers have speculated on the ontological significance of this fact. Little contribution to the literature has been made by English anatomists.

THE GASTRO-COLIC REFLEX.

This structure is difficult to define in the injected specimen. It is stated to connect the stomach and colon sometimes in some people and always in some people, but not always in all people or always in other people. Generally most definite ten minutes after breakfast, it is thus one of the causes of *The Times*, missing the 8.47 and corridor trains. In order to assist the student, the more certain relation are as follow:—

Paternal.—I. Leo and C. Kal Valve. These have always been the main supporters of the entero-political dogma "Government of the colon, for the colon, by the colon."

Lateral.—Superficial fascia, deep fascia, pelvic fascia, infundibuliform fascia.

Maternal.—Dura Mater (who brought him up with a hard hand), Miss Enteric Vessels, Auntie Dysenteric Serum.

Medial.—Spine, erector spinæ, arteria spinalis retinæ, M. constrictor vel extractor spinalis proprius.

The gastro-colic reflex, although not a cause of surgeons, is nevertheless a GOOD THING.

TEST PAPER ON CHAPTERS VII, VIII AND IX.

Question i: Which do you consider the more interesting, the ovary, the kidney or both?

Question ii: What is NOT external, NOT abdominal and NOT a ring? Who said this and why? (be Biblical).

Question iii: Explain the difference in the female between the sustentaculum tali and the receptaculum chyli.

Question iv: Illustrate by graphs how angry you would be if it were suggested to you that—

(a) the intimate anatomical relation between the corpus luteum and the islands of Langerhans is responsible for the phenomenon of hippus in aphrodisiacs.

(b) you had failed to grasp the lesser sack.

VIKTOR HENSEN.*

"to keep men out of their Urnes."

HEAVIER and heavier from generation unto generation grows the burden of historical prejudice. Embarrassing questions of priority, with their atmosphere of intellectual integrity no less than of littleness, intrigue those whose leisure is infinite and who are not congenitally immune to gossip.

From your student days, the venerable figure of Claude Bernard is associated in your minds with the discovery of the glycogenic function of the liver in 1857. He was then in his forty-fifth year, and already Fame had knocked at his door. Seventy-six years ago, at a meeting of the Physikalisch-medizinische Gesellschaft held in Würzburg on July 18th, 1856, a medical student of 21 years, Viktor Hensen, in a lecture on "Sugar Formation in the Liver," announced that this organ contains a substance capable of producing sugar by fermentation. A series of experiments on animals like the rabbit, dog, cat, pigeon, frog, mouse, and ox, led him to the discovery of glycogen, whose properties he demonstrated to the local Naturwissenschaftlicher Verein der Studirenden on December 11th, 1856, and to Virchow, Hoppe, Gerlach, and others at the Pathological Institute on April 1st, 1857. His work was published in the *Verhandlungen der physikalisch-medizinischen Gesellschaft in Würzburg*, 1857, vii, pp. 219-22, and in the *Archiv für pathologische Anatomie*, 1857, xi, pp. 395-8, where he fully describes his technique for obtaining glycogen from the liver of a rabbit fed for a few days on oats and cabbage. In the second paper he mentions the publication of Claude Bernard's discovery in the *Gazette médicale de Paris*, dated March 28th, 1857, a copy of

* A communication made at a meeting of the Osler Club on January 22nd.

which he obtained from Virchow on April 12th. His own paper was submitted for publication on April 13th. "As Bernard succeeded in having found out this important process by himself, I have almost to take care that my part in this discovery should not be forgotten altogether."

Viktor Hensen, born in Schleswig on February 10th, 1835, became Professor of Physiology at Kiel in 1868. He was a tremendous worker and a popular teacher. Though retiring and taciturn, he had a keen sense of humour and the imagination of an artist. He died on April 5th, 1924, at the age of 89.

While in this country his discovery of glycogen is generally ignored, in the German literature it is dismissed with "honourable mention."

Hensen has found eponymic immortality in English and American medical dictionaries. He is kept out of his Urne by such familiar terms as "Hensen's canal" (canalis reuniens of internal ear), "Hensen's cells" (sustentacular cells of organ of Corti), "Hensen's line" (the light stripe in a dark sarcomere), and "Hensen's node" (a collection of cells at the anterior end of the embryonic streak).

W. R. BETT.

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STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

Results.

- Saturday, January 23rd, v. Pontypool, at home. Lost, 5—6.
 Saturday, January 30th, v. Old Millhillians, at home. Won, 10—0.
 Wednesday, February 3rd, v. University College, Dublin, away. Won, 5—3.
 Saturday, February 6th, v. Old Haileyburians, at home. Lost, 3—8.
 Tuesday, February 9th, v. Guy's (2nd round Hospital Cup). Lost, 0—11.
 Saturday, February 13th, v. Devonport Services. Scratched.
 Saturday, February 20th, v. Old Paulines, away. Won, 6—0.

Results to Date (February 20th).

Played.	Won.	Drawn.	Lost.	Points.	
				For.	Against.
26	14	0	12	238	230

"A" XV.

Wednesday, February 17th, v. Guy's "A," 2nd round Junior Hospital Cup, home. Won, 12—10.

The rugby season is approaching its end, and with only nine more matches to complete we shall then close one of the most successful and yet one of the most disappointing seasons that the club has experienced during recent years.

In club matches we have had some of the most enjoyable games imaginable; we have beaten quite a number of our old rivals, while with others we have had exceptionally close games. But in our cup-ties hopeless failure overtook every effort that was made, and we can but congratulate Guy's on their magnificent display.

Against Pontypool, on January 23rd, we were perhaps fortunate in keeping the score so close, but any faults that were evident in the Hospital play were outshone on the following Saturday, when the Old Millhillians were entertained at Winchmore Hill. This was perhaps the most encouraging match of the season, for in every department of the game a great deal of spectacular play was shown by the Bart.'s XV. The opposition included such well-known names as Spong, Sobey, Carris and Lawther, the Scottish International, and it was little wonder that by defeating the Old Boys we looked forward to a successful voyage through the first Cup match on February 9th.

In Dublin, on February 3rd, further laurels were heaped upon our heads by defeating University College, Dublin, in our first encounter with this club. This was again a match in which we were lucky, but great credit is due to the dogged defence shown especially by the backs against the strong attacks of the "national." It is hoped that this fixture will become a permanent one, for not only was the game most enjoyable, but also the hospitality and dance given in our honour.

On Saturday, February 6th, it was decided to rest the 1st XV owing to the proximity of the Guy's match, and so a complete "A" XV, except for Mundy in the pack, turned out against the Old Haileyburians at Winchmore Hill. The "A" must be congratulated on their fine performance.

A report is given of the Cup match against Guy's and it is therefore out of place to say more than a word of sympathy to all the Bart.'s supporters who watched what must have been a very painful afternoon's entertainment.

The return match against the Old Paulines on February 20th at Thames Ditton did not produce spectacular football, for with a bitter wind blowing the backs were frequently unable to hold the ball, and it remained for Darmady to repeat our victory by converting two penalty goals. The feature of the match from the Bart.'s point of view was the forward rushes and the encouraging play of J. D. Wilson, who made his first appearance in the XV as a wing forward.

The "A," who have experienced a fairly successful season so far, atoned somewhat for the failure of the 1st by defeating Guy's "A" in the second round of the Junior Hospital Cup. We see no reason why they should not retain the Cup, which is now looked upon as their property, as we have won it more often than any other hospital in recent years.

Casualties have fortunately been few this season, but during recent matches we have been unlucky, for not only was Lewis unable to play against Guy's owing to a knee injury, but J. R. R. Jenkins has been warded since the Pontypool match with what appeared to be a synovitis of the ankle-joint; we wish him a speedy recovery, for as a hard-working secretary and one of our best forwards we miss him greatly.

ST. BARTHOLOMEW'S HOSPITAL v. GUY'S HOSPITAL.

Played at Richmond on Tuesday, February 9th. (From *The Morning Post*.)

Guy's beat St. Bartholomew's, the holders, in the second round of the Hospitals Cup competition at Richmond Athletic Ground yesterday by a goal and two tries (11 points) to nothing, and, in doing so, conclusively proved themselves the superior team all round.

The surprise of the match was the way in which the Guy's forwards

not only held but mastered the Bart.'s pack in most branches of forward play. This development may have been due in part to the inability of two of Bart.'s best forwards, B. S. Lewis and J. R. R. Jenkins, to turn out; but it should not be forgotten that Guy's, too, were without an excellent second-row man, I. C. Robin.

Quite early in the game it was seen that the expected forward superiority of Bart.'s was not materializing; in fact, the ability of O'Shea to get the ball in the set scrums became so pronounced that Guy's were soon disclaiming the throw-in from touch in favour of forming down. In this formation a tribute should be paid to Batchelor, O'Shea and Cunard, who successfully got under the Bart.'s front row time after time and forced them up into a losing position.

As is customary in a match of this description there was a vast deal of scrappy forward play, with prolonged mauls in the loose and "mass" tackling at the line-out.

Behind the scrum there was only one side in it, and that was not Bart.'s, whose passing was laboured and inaccurate, though Kingdon and Curtiss, individually, each made a couple of good runs. Guy's might have increased their score had Ashdown not had a tendency to lie up too far for his pass, which resulted in three good openings, the workmanship of Alexander and Giesen, running to waste from the forward passes which resulted.

The "class" of Alexander and Giesen in the centre was constantly in evidence, not only for their crisp attacking work, but also for the diligence and promptness with which they remedied any omissions, nearer the scrum, to keep an eye on the wily and elusive Taylor.

Unsuccessful drops at goal by Lewis and Kingdon and a series of charged-down kicks by Bart.'s characterized the alternating attacks of the first half-hour. Then a movement by Clarke, Morgan and Ashdown ended in the last-named being thrown into touch near Bart.'s line, and from the ensuing throw-in and *mêlée* the ball went to Alexander, who cut through skilfully for a well-deserved try.

Kingdon ran well through some weak tackling, but he had "lost" the rest of his side, and his kick over Clegg's head was too hard. This was the nearest that Bart.'s ever looked to a score, and early in the second half, after Ashdown had gone over but been recalled for a forward pass, Giesen gained a second try similar to the first, and Hogbin this time converted.

Bart.'s forwards brought off some good loose rushes in the course of the remaining play, but the result was put beyond doubt when Hogbin broke away on the blind side in mid-field and passed to O'Shea, Johnson meeting the latter's wild pass with his foot and, by adroit ball-control, dribbling over and touching down for a try.

Team.—C. W. John (*back*); J. G. Youngman, A. H. Pirie, L. M. Curtiss, J. D. Powell (*three-quarters*); J. R. Kingdon, J. T. Taylor (*halves*); W. M. Capper (*capt.*), G. W. Hayward, G. D. Briggs, J. M. Jackson, E. M. Darmady, R. Mundy, K. J. Harvey, D. W. Moynagh (*forwards*).

ASSOCIATION FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. OLD BRADFIELDIANS.

Played at Winchmore Hill on Saturday, January 23rd.

Owing to injuries, the Hospital was compelled to make four changes for this game, and it was therefore very encouraging to score such a clear victory against strong opponents.

The visitors soon took up the attack, and it was some time before the Hospital forwards approached their opponents' goal. The right wing was prominent, and it was from that side of the field that the first score originated. Wheeler went through, and centred for Shackman to score while on the run. The game continued evenly for a while, with the Bradfieldians finding the Bart.'s defence very sound, Hunt, Shields and Maidlow being prominent. However, our forwards were also in dangerous mood, and whenever they broke away they appeared likely to score. Brookman had hard luck with a good attempt, and a little later the ball was again worked up in good style on the left wing, for Royston to centre to Wheeler, who put us further ahead.

Bradfield attacked desperately after this, and, just before half-time, were rewarded with a good goal by their inside-right.

The second half began with Bart.'s on the defensive, but playing up well. The forwards soon had another opportunity to demonstrate their new-found deadliness in front of goal when Wheeler scored, after he and Shackman temporarily exchanged positions.

During the next 20 minutes the Hospital defence showed up very well indeed. The visitors attacked continuously, and with great

vigour, and the Bart.'s inside forwards had to assist in defence. However, the goal only fell on one occasion, which was greatly to the credit of all concerned. Hunt was particularly noticeable for his good work, and Johnson played extraordinarily well in goal, giving by far his best display of the season up-to-date.

The forwards, inspired by the example set them by the rest of the team, played up splendidly towards the end, and Shackman made the result obvious by restoring our two-goal lead. Not content with this, Royston dribbled through very neatly and made our win even more impressive.

A satisfactory feature of this success was the good form shown by the three players brought in to fill the places of those injured.

Result: Bart.'s 5; Old Bradfieldians, 2.

Team.—D. J. Johnson (*goal*); J. Shields, A. H. Hunt (*backs*); J. K. Brownlee, R. E. Owlett, W. M. Maidlow (*halves*); R. C. Dolly, F. E. Wheeler, R. Shackman, G. H. Brookman, G. R. Royston (*forwards*).

1st Round Inter-Hospitals Cup Competition, 1931-32.

ST. BARTHOLOMEW'S HOSPITAL v. GUY'S HOSPITAL (holders).

Played at Honor Oak on Monday, January 25th.

Guy's had beaten us 4-2 in the Final last year, taking the Cup from us, and we were therefore particularly anxious to relieve them of it this season. Bart.'s were able to field their strongest side, and it was interesting to compare the team with that which played Guy's at the Crystal Palace last March. Only three of the positions in the Bart.'s side were occupied by the same men on both occasions; Guy's, on the other hand, had the majority of last year's team still available. Nevertheless the Hospital put up a much better relative performance this year than last, and were, on the whole, unlucky to lose.

The team was handicapped by the late arrival of Shields, who had difficulty in finding the ground. Guy's took full advantage of their good fortune, and kept Bart.'s on the defence for the first 15 minutes of the game. During this period they scored once from close in, and it was with difficulty that they were prevented from adding to their score. However, with the completion of our team, Bart.'s gradually assumed the offensive, and came near to scoring on two or three occasions. This pressure was maintained for several minutes; the forwards were finding each other fairly well, and the team was only slightly infected by the inevitable cup-tie excitement. Eventually, after 25 minutes' play, Brookman equalized with a good shot through a crowd of players. The rest of the first half was fairly even, with Bart.'s having slightly more of the attack. The two wing men, and particularly Gilbert, were plying with good passes, and kept the Guy's defence busy. However, there was no further score before half-time, and Bart.'s crossed over feeling they had done well to deserve equality at the interval.

The second half began as the first had ended—with both sides striving hard to obtain the lead, and with Bart.'s looking the more likely to be successful. After about 10 minutes' play our efforts were rewarded with a nice goal. Brookman made a perfect pass down the middle, and Wheeler shot well to score as the goalkeeper advanced to meet him.

Following this goal Guy's appeared a well-beaten side. Bart.'s obtained the ball from almost every tackle, and were playing with great confidence. It seemed inevitable that we should increase our lead, but unsteadiness near goal proved our undoing. However, several shots were on the target, and with ordinary luck we should have scored at least two more goals—the ball striking the goalposts, with the goal-keeper beaten. Nevertheless, the main reason for our failure to score was the inability of our extreme wing men to take advantage of the many opportunities provided them.

Bart.'s continued to press for 15 minutes, but without avail, and then Guy's showed themselves to be excellent opportunists, when they regained the lead. First Hunt, who otherwise played extraordinarily well, lost the ball to the opposing outside-right, who centred well, and set his centre-forward a simple task. Bart.'s returned to the attack for a moment or so, but much of the life seemed to have gone out of the team, and, soon afterwards, another slip gave the Guy's outside-left the opportunity of scoring their third goal. Guy's now had the upper hand, and though they were seldom really dangerous, they attacked persistently for the rest of the game.

Result: Guy's, 3; Bart.'s, 2.

Thus, for the first time in four seasons, Bart.'s will not figure in the Final at Crystal Palace, but the team can console itself with the

thought that it came very near to victory, and that there is still a very excellent chance of winning the London University Cup, the semi-final round of which will be played ere the JOURNAL is published.

Team.—D. J. Johnson (*goal*); J. Shields, A. H. Hunt (*backs*); A. Hollinrake, D. R. S. Howell, W. M. Maidlow (*halves*); R. G. Gilbert, F. E. Wheeler, R. Shackman, G. H. Brookman, R. C. Dolly (*forwards*).
D. R. S. H.

HOCKEY CLUB.

2nd Round Inter-Hospitals Cup.

ST. BARTHOLOMEW'S HOSPITAL v. UNIVERSITY COLLEGE HOSPITAL.

Played at Perivale on January 28th. Won, 5—0.

Bart.'s were fortunate in drawing a bye in the first round of the cup-ties and so passing straight into the second round. Here we were up against a team of moderate strength whose chief hopes lay centred in two Old Blues playing for them. The ground was somewhat heavy after rain and soon cut up, little good hockey being seen. A feature of the game was the excellent play of Hindley at back; it was quite the best game he has played for the Hospital. Wright also did well, with the result that Hodgkinson had little to do, though he made one or two very good saves. The halves were steady, and the forwards combined fairly well, though the shooting left something to be desired; perhaps the state of the ground accounted for this. The result was very satisfactory, and we hope the team will do as well and better in the next round.

Team.—H. L. Hodgkinson (*goal*); P. M. Wright, G. T. Hindley (*backs*); V. C. Snell, K. W. Martin, J. H. Hunt (capt.) (*halves*); R. T. Davidson, C. A. Hinds Howell, A. D. Iliff, C. L. Hay-Shunker, J. Lockett (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL v. R.M.C. SANDHURST.

Played at Sandhurst on Saturday, February 6th. Won 5—0.

This was quite one of the best games we have had this season, played on a perfect ground on a fine sunny afternoon. The score hardly reflects the run of the play for the teams were very evenly matched, and, in fact, Sandhurst to begin with were much quicker on the ball. They were unlucky in not scoring, one shot in particular which should have tested Hodgkinson soaring over the top of the goal.

The game was played at a very fast pace all through, and for once the Hospital team outlasted their opponents, being very much fitter at the end. From the beginning Sandhurst pressed, and there followed some anxious moments with the ball in our circle. But some good work by the defence kept them out, and Bart.'s soon took the ball up the other end and scored. At half-time the score was 1 to nil in our favour, but soon after resuming play Hay-Shunker shot a good goal from what appeared to be an impossible position. And towards the end of the game Sandhurst seemed to go to pieces, our last three goals being scored fairly easily and most of the play being in their half of the field.

Snell played a good game at half, but let his wing, one of the best men on the field, go clear away once or twice too often. Hunt got through a vast amount of work, and fed Symonds well with some good passes. The latter made some excellent runs down the wing, but should learn to centre earlier. Davidson on the right sent across some good ones, of which the insides might have taken more advantage at times.

A very pleasant and enjoyable game, which augurs well for the next round of the Cup-ties soon to be played.

Team.—H. L. Hodgkinson (*goal*); P. M. Wright, G. T. Hindley (*backs*); V. C. Snell, K. W. Martin, J. H. Hunt (capt.) (*halves*); R. T. Davidson, C. A. Hinds Howell, A. D. Iliff, C. L. Hay-Shunker, J. W. Symonds (*forwards*).

Semi-Final Inter-Hospitals Cup.

ST. BARTHOLOMEW'S HOSPITAL v. GUY'S HOSPITAL.

Played at Richmond on February 10th. Won, 8—1.

Weather conditions were about as bad as they possibly could be for this match. The ground was frozen hard and covered with a thin coating of snow, and it was bitterly cold. Despite this, however, it was quite an enjoyable game for everyone concerned except perhaps the goalkeepers.

Bart.'s pressed from the start and were soon one goal to the good,

and two more followed in quick succession, Hinds Howell doing a lever run through on his own. Guy's rallied and scored their only goal with a good shot just before half-time. In the second half Guy's pressed harder, and both our backs had more to do, Hindley particularly being prominent for the defence. Two corners, one after the other, were given against us but fortunately were not taken advantage of, and it looked as though the final result would be closer until the Bart.'s forwards ran through again and scored. Thereafter we went ahead, and had little difficulty in keeping them out of our circle until time.

The whole team played well, and it is difficult to single out any particular member for mention, which is as it should be, for combination together as a team will count more than individual brilliance in the final to be played next month.

Team.—H. L. Hodgkinson (*goal*); P. M. Wright, G. T. Hindley (*backs*); V. C. Snell, K. W. Martin, J. H. Hunt (capt.) (*halves*); R. T. Davidson, C. A. Hinds Howell, A. D. Iliff, C. L. Hay-Shunker, J. Lockett (*forwards*).

RIFLE CLUB.

The Miniature Range has been well supported this term and there are several promising new members. The entries for the Lady Ludlow and Sir H. J. Waring Cups have been large and plenty of good scores have been put up. The Club has recently purchased a new rifle of the latest type, which has produced a noticeable improvement in the standard of the shooting.

The team have put up some good scores and the match totals are still increasing. Six matches have been shot up to date, with a total of two wins, three losses and one draw. In this last match G. S. Druce scored the first match "possible" recorded for some years.

If the club continues to receive the support it is receiving at present it is hoped to start a "B" team, challenges for which have already been received.

MATCHES.

January 7th v. L. C. Smith & Corona R.C.: Bart.'s, 571 (G. S. Druce, 99); L. C. Smith & Corona, 569. Won by 2 pts.

January 14th v. Aquarius R.C.: Bart.'s, 563; Aquarius, 570. Lost by 7 pts.

January 21st v. Dunlop R.C.: Bart.'s, 572 (J. S. Bailey, 99); Dunlop, 577. Lost by 5 pts.

February 2nd v. London Hospital R.C.: Bart.'s, 571; London Hospital, 540. Won by 31 pts.

February 4th v. Swansea R.C. "B": Bart.'s, 575; Swansea "B", 582. Lost by 7 pts.

February 11th v. 5th Battn. Bedfordshire and Hertfordshire Regiment: Bart.'s, 579 (G. S. Druce, 100); 5th Battn. Bedfordshire and Hertfordshire Regiment, 579. Drawn.
D. O. D.

UNITED HOSPITALS HARE AND HOUNDS.

U.H.H. v. METROPOLITAN POLICE A.C.

At Imber Court.

This race was run on the coldest day there has been for some time; the ground was covered with snow and there was a howling gale blowing. We started with the wind behind us, fortunately, W. F. Butler (M.P.A.C.) setting a fast pace, closely followed by Kinnear and Dalley (Bart.'s). Next came Dalziel (M.P.A.C.), Strong (Bart.'s) and Smyth (London), in that order. In the shelter of the reservoir the first three went away from the rest and Smyth came up to them. Butler was continuously challenged on the way home, but just managed to keep ahead to win in 29 min. 49 sec. Smyth, Kinnear and Dalley finished together in 29 min. 56 sec.

Points:

1. U.H.H., 2, 3, 4, 6, 8, 12 = 35.

2. M.P.A.C., 1, 5, 7, 9, 10, 11 = 43.

U.H.H. v. OXFORD UNIVERSITY CROSS-COUNTRY CLUB "A."

At Oxford.

For an "A" team Oxford turned out an extremely strong team, which included no less than five "blues," and as the Hospitals had a team much weakened by sickness, the result was rather unfortunate

for us. The race soon developed into a procession, C. J. Mabey (St. Edmund Hall) leading throughout, followed by five more Oxford men. At the top of "Shotover" none of our men were in a position to cause any anxiety to Oxford, and although J. F. Cornes, the winner of the Inter-Varsity Cross-Country race, had to drop out, Oxford had the first five men home, thus winning by the minimum score.

U.H.H.H. v. CAMBRIDGE UNIVERSITY "A."

At Richmond.

Conditions were favourable for fast times, and H. Brown (St. Edmund Hall) set off very fast, followed by Strong, Kinnear, Smyth, Dalley and Sandiford, all Hospital men. Brown, however, could not last the pace, and Kinnear and Smyth took the lead for a little while, soon losing it to Gething (Sidney Sussex), who had come up in the meanwhile. These seven ran in a bunch most of the way, the lead continually changing and the rest of the field tailing out behind. The individual winner was R. T. Gething, and his time was 35 min. 42 sec. He was closely followed by Smyth (London) and Kinnear (Bart.'s), who finished together in 35 min. 51 sec. Strong (Bart.'s), who had been running well, got a "stitch" about a mile from home, and was beaten by Brown. The Hospitals packed very well indeed and deserved to win.

Points:

1. U.H.H.H., 2, 3, 5, 6, 7, 10 = 33.
2. Cambridge, 1, 4, 8, 9, 11, 12 = 45.

G. D.

REVIEWS.

CLINICAL NOTES ON DISORDERS OF CHILDHOOD. By D. W. WINNICOTT, M.A., M.R.C.P. (London: William Heinemann, 1931.) Pp. viii + 216. Price 10s. 6d.

This is an intensely interesting book dealing with diseases of children from the point of view of symptomatology. Dr. Winnicott has given a prominent place to the emotional life of the child. "Emotional development," he says, "is normally difficult and commonly incomplete. Most of the common symptoms of children arise from difficulties of emotional development." While engaged in his difficult task the child needs friends, and much of the doctor's work is a specialized form of friendship.

The first chapters deal with history taking and physical examination and form an excellent guide. "Study the child and not the disease" is a principle to which the author adheres throughout the book. The chapters on rheumatic carditis are extremely good. The author first describes the examination of the heart in the normal child, and the variations which may be met with as a result of apprehension on the part of the patient. The fallibility of the stethoscope is fully proved. He urges that the diagnosis of active rheumatic heart disease must be made long before physical signs appear in the heart itself. Every case which shows rheumatic manifestations, such as joint involvement, chorea or recurring sore throats must be regarded as a heart case and treated accordingly. Conversely if a child is not subject to these symptoms, great caution must be exercised in diagnosing active carditis, whatever the signs found on examination of the heart. The normal heart of an anxious child may give physical signs closely resembling those of rheumatic carditis. A table is given of the reasons for which children are being wrongly treated as rheumatic and kept in bed and prevented from playing games. Dr. Winnicott boldly states that "growing pains" are not rheumatic, but closely bound up with other anxiety symptoms. This is a statement with which most clinicians will entirely disagree.

We are then led on to a consideration of anxiety and other psychological disorders in children. These chapters are very interesting and are illustrated by a series of admirable case-notes, which are so good that they form a unique feature of the book—probably the most valuable part of it.

It is to be regretted that practically no mention is made of treatment, and that many common diseases of children are dismissed in a few lines, or not mentioned at all. We hope that the author will produce another such book in the near future, giving his views on fevers and diseases of the alimentary and respiratory tracts.

Dr. Winnicott is to be congratulated on writing an original book of such absorbing interest that the reader is reluctant to put it down until finished. There is no doubt that it forms a useful contribution to the study of the disorders with which it deals, and that it merits a place on the bookshelves of every practitioner who is called upon to treat children.

THE FUNDUS OF THE HUMAN EYE. An Illustrated Atlas for the Physician. By ERNEST CLARKE, C.V.O., M.D., F.R.C.S. (Oxford Medical Publications: Humphrey Milford, 1931.) 51 coloured plates. Price 18s.

This atlas supplies a real need, and will prove a most useful and convenient handbook for the physician who carries an ophthalmoscope. The value of this instrument can scarcely be exaggerated, and the electric ophthalmoscope is now within the reach of everybody's purse and skill.

The fifty-one plates, which, with their legends, constitute the book, are taken from the collection of paintings in the art department of Messrs. Hamblin; they are admirably reproduced, and each plate is fixed with a linen strip so that the atlas can be opened flat. The selection is well made, the variations in the normal fundus being fully displayed. We could wish for a larger number of plates of albuminuric retinitis, showing the appearances of the various stages more fully. Only the commoner conditions are illustrated.

The legends, written by Mr. A. H. Levy, are brief and to the point. A short introduction, explaining the technique of focusing and using the electric ophthalmoscope, would be a useful addition; the student would appreciate some definite order to adopt in examining the structures of the fundus.

We have nothing but praise for this book, and in view of the excellent method of binding and the high quality of the plates, we regard the price as reasonable.

A HANDBOOK OF MIDWIFERY. By RICHARD E. TOTTENHAM, M.D., F.R.C.P.I. (London: J. & A. Churchill, 1931.) Pp. ix + 307. 102 illustrations. Price 10s. 6d.

This admirable little book fulfils its purpose of providing for students and midwives an introduction to obstetrics. The author confines himself to material which is of practical use, and seldom enters the realms of theory. For this reason his book is scarcely comprehensive enough for the student who is about to take his finals. For example, it is simply stated that the causation of placenta previa is unknown; no theories are provided. There are a few minor points in which Dr. Tottenham's teaching disagrees with ours. We do not give ergot in cases of threatened abortion, nor pituitrin in the first stage of labour, rigidly withholding it in the second and third stages. For eclampsia, Tweedy's treatment is given in detail, and Stroggoff's is merely outlined. The manual rotation of the head in cases of persistent occipito-posterior positions is not described, and is stated to be seldom indicated; we feel, however, that it is more deserving of space than is the Baudelocque-Schatz manoeuvre for face presentations. The latter is fully described. Primary and secondary uterine inertia are not distinguished. Apart from these matters we agree whole-heartedly with the author's methods. An admirable chapter describes in detail the technique of the minor obstetrical operations such as douching the uterus, preparation of the vulva and vagina before manipulations, repair of perineal and cervical lacerations and the application of forceps. Pelvimetry is described in full detail, and the author's own pelvineter is introduced; it appears to have many advantages. The important subject of puerperal sepsis is discussed at some length and the exposition of it is excellent. No mention is made of abdominal hysterotomy in the treatment of vesicular moles; this method is gaining popularity, and is surely superior to manual removal or the use of spoon forceps. The author steers a middle course between controlling the fundus in the third stage of labour and the Rotunda method of leaving the fundus entirely alone: he advocates pressure by the ulnar border of the hand on the abdomen *above* the level of the fundus.

Like all Churchill's books, this volume is well and attractively bound and beautifully illustrated.

WHEELER AND JACK'S HANDBOOK OF MEDICINE. Revised by JOHN HENDERSON, M.D., F.R.F.P.S.(Glas.). Ninth edition. (Edinburgh: E. & S. Livingstone, 1932.) Pp. xvii + 654. Price 12s. 6d.

There is no need to introduce to readers of the JOURNAL this old favourite. That it has reached its ninth edition in just under forty years is sufficient evidence of its usefulness and popularity. The present edition, looking a little scriptural with its soft black covers and round edges, has been completely revised, certain sections having been entirely rewritten, notably those dealing with pernicious anaemia and arthritis deformans. New chapters deal with coronary thrombosis, various neuroses, narcolepsy and hepatic efficiency tests. The size of the book has been but little increased, and it makes no claim to be a text-book. There is no doubt, however, that it will prove as popular and successful as its predecessors, being sufficiently comprehensive for the majority of students approaching their finals.

MEDICAL EMERGENCIES. By CHARLES NEWMAN, M.D., M.R.C.P. (London: J. & A. Churchill, 1931.) Pp. ix + 128. Price 8s. 6d.

This little book is issued as a companion volume to *Surgical Emergencies in Practice* by Romanis and Mitchiner, published earlier in the year. It is pointed out that medical emergencies are often much more urgent than surgical emergencies; it therefore seems appropriate that a series of conditions requiring accurate diagnosis and prompt correct treatment should be grouped together.

The first chapter consists of a list of poisons and their appropriate remedies. The author then deals very explicitly with the subjects of coma and convulsions. Heart failure, hæmorrhage, asphyxia and the colics are then dealt with. The accounts are all brief, and where various methods of treatment are available only one is described. The prevention of such emergencies as eclampsia and tetanus does not come under the scope of this book and is therefore omitted. A very useful chapter deals with sudden insanity and describes the proper procedure. Technique of blood transfusion, tracheotomy, lumbar puncture and intravenous injection is given in full detail. The book contains much that is useful in an easily accessible form, and it can be recommended with every confidence to students, and especially to house-physicians at the outset of their career. The information is, however, of an elementary nature, and should be at the finger-tips of every qualified man.

THE STUDENTS' HANDBOOK OF SURGICAL OPERATIONS. (London: Cassell & Co., Ltd., 1930.) Pp. xi + 535. With 190 illustrations. Price 10s. 6d. net.

This edition, the fifth, edited by Mr. Cecil Wakeley, can be said to carry on truly the teaching traditions, laid down by its first editor, Mr. Jonathan Hutchinson, some thirty-eight years ago.

The earlier chapters, dealing with amputations, ligature of arteries, excision of joints, etc., would amplify any course of instruction in operative surgery; while the later ones, on regional surgery, are of great value to the student in revising for his final examinations. The technique of radium therapy is briefly outlined, special reference being made to treatment of cancer of the mouth, breast and rectum.

The injection method for hæmorrhoids and varicose veins is alluded to and sections are devoted to other recent work, such as the treatment of congenital dislocation of the hip, and plastic surgery.

The work throughout is fully illustrated by lucid and instructive drawings, and is written in a clear and concise manner, while the "comments" at the end of each section add further value to an excellent book, which every student should have in his possession.

MANUAL OF BACTERIOLOGY. By ROBERT MUIR, M.A., M.D., F.R.S., etc., and the late JAMES RITCHIE, M.A., M.D., F.R.C.P.(Ed.). Revised by CARL H. BROWNING, M.D., D.P.H., F.R.S., and THOMAS J. MACKIE, M.D., D.P.H. Ninth edition. (London: Humphrey Milford, 1932.) Pp. xxiv + 866. With 212 illustrations and 6 coloured plates. Price 20s. net.

There are few subjects ancillary to medicine in which knowledge advances so rapidly at the present time as bacteriology. During

the five years since the last edition of this text-book there have been many changes in the subject, so that clinical workers and students will appreciate the revising of such a well-known manual.

The size is not appreciably different from former editions, although the whole text has been largely rewritten and new illustrations added. The bibliography has been reduced and only the more recent works included, while the sections on Filter-passing Viruses, Immunity and the Streptococci have received special attention in the light of recent work.

It is unnecessary to give this popular text-book further recommendation.

FUNDAMENTAL PRINCIPLES OF RAY THERAPY. By WILLIAM BEAUMONT, M.R.C.S., L.R.C.P. (London: H. K. Lewis & Co., Ltd., 1931.) Pp. viii + 124. Price 6s. net.

We regret that we are unable to recommend this book to those for whom it was written, viz. nurses, medical students and medical practitioners. It is marred by many loose, inaccurate or misleading statements, and cannot be regarded as a reliable exposition of the principles of ray therapy.

POCKET MONOGRAPHS ON PRACTICAL MEDICINE. General Editors: ARNOLD SORSBY, M.D., F.R.C.S.; MAURICE SORSBY, M.D., F.R.C.S. (John Bale, Sons & Danielsson, Ltd., 1932.) Price 2s. 6d. net each.

THE ACUTE ABDOMEN. By C. H. FAGGE, M.S., F.R.C.S. Pp. 92. RADIUM AND CANCER. By H. S. SOUTTAR, C.B.E., M.D., F.R.C.S. Pp. 64.

DISEASES AND DISORDERS OF THE DIGESTIVE ORGANS. By ADOLPHE ABRAHAMS, O.B.E., M.D., F.R.C.P. Pp. 110.

This attractive new series presents much that is wise, useful and readable in cheap and handy form. The information is terse and accurate, and print and paper are good.

Mr. Fagge tells simply and graphically of the various abdominal catastrophes, their diagnosis and treatment, pre- and post-operative. Mr. Souttar in his accustomed elegant style discusses the physical properties of radium and its application to surgery, giving both his own and other people's methods. The last chapter is devoted to accidents following the use of radium. On p. 45 Halsted's name is incorrectly spelt.

Dr. Abrahams' contribution to the series is learned and vivid. He deals with such conditions as peptic ulcer, appendix dyspepsia and flatulence, and devotes some space to the test-meal and the examination of the stools for occult blood. The quotation on p. 60 from the late J. C. Hemmeter is of poignant interest.

A GUIDE TO BIRTH CONTROL LITERATURE. By NORMAN E. HINES. (London: Noel Douglas, 1931.) Pp. 46. Price 3s. 6d. net.

This little book consists of a bibliography of the numerous works that have been written in recent years on birth control. It does not pretend to be complete, but its aim is to place before the busy physician or the misguided layman a guide to the literature of the subject. It is divided into three parts—technique, economic and sociological background of birth control, and continental literature on technique; each part is brief, and contains a list of the best works under the respective headings.

NOTES ON RADIUM THERAPY. By H. A. COLWELL. (London: H. K. Lewis & Co., Ltd., 1931.) Pp. x + 165. 6s. net.

This little book is one of the best introductions to radium therapy with which we are acquainted. Beginning with a brief account of the physics of radio-active substances and a description of radium containers, the author considers in turn the chemical and biological effects of the emitted radiations, and their clinical applications.

This is followed by concise accounts of the techniques most in favour at the present time for the radium treatment of carcinoma of the breast, tongue, cervix uteri, rectum, etc., as well as for rodent ulcer.

The author comments on the dangers, contra-indications and results of the various treatments, and proves himself a competent guide to the student sitting his "finals," and a lucid expositor to others interested but not yet learned in the subject.

In spite of a few minor blemishes, we heartily recommend the book.

MEDICAL ELECTRICITY FOR STUDENTS. By A. R. I. BROWNE. Third edition. (London: Oxford University Press, 1931.) Pp. xvii + 245. Price 12s. 6d.

This book is intended primarily for students preparing for the Examination in Medical Electricity conducted by the Chartered Society of Massage and Medical Gymnastics. The fact that three editions have been called for in ten years is evidence of its popularity. A perusal of the contents shows that this popularity is justified by the careful and comprehensive treatment given by the author.

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

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BALL and EVANS: *Diseases of the Kidney*.

BERTWISTLE: *A Descriptive Atlas of Radiography*.

BISHOP: *Arterial Sclerosis*.

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JACOBI: *Atlas of Dermochromes*, with English Text by HENRY MACCORMAC, C.B.E., M.D., F.R.C.P.

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ACKNOWLEDGMENTS.

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The following have been admitted *Members*:

Franklin, A. W., Landor, J. V., Whyte, A. D. S.

Royal Colleges of Physicians and Surgeons.

The following Diplomas have been conferred:

D.P.H.—Simmonds, F. A. H.

D.L.O.—Siddiqi, M. A. H.

D.P.M.—Pentreath, E. U. H.

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The following have completed the Examination for the Diplomas of **M.R.C.S., L.R.C.P.**, and have had the Diplomas conferred on them:

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A POINTMENT.

HENSMAN, J. S., B.Ch.(Cantab.), M.R.C.S., L.R.C.P., appointed Honorary Anaesthetist to the Queen's Hospital for Children, Hackney.

BIRTHS.

BELL.—On February 2nd, 1932, at Sevenoaks, to Ruth (*née* Grandage) wife of William Duncan Bell—a daughter.

BLACKBAY.—On January 5th, 1932, at Zomba, Nyasaland, to Beatrice Mary, wife of Dr. E. J. Blackbay—a son.

BRIGGS.—On February 6th, 1932, to Constance (*née* Clarke), wife of Dr. W. A. Briggs, 6, Minster Yard, Lincoln—a son.

McCURRIC.—On February 23rd, 1932, at 19, Palmeira Avenue, Hove, to Bettine (*née* Ellis), the wife of H. J. McCurric, M.S., F.R.C.S.—a son (stillborn).

ROWELL.—On February 4th, 1932, to Marie, wife of Dr. Leslie Rowell, of 10, Chapel Street, Belgrave Square, S.W.—a daughter.

WILLCOCKS.—On February 21st, 1932, at Springfield, Chelmsford to Hope, wife of Dr. Robert W. Willcocks—a daughter.

MARRIAGE.

LANGHORNE—JESSOP.—On December 18th, 1931, at St. Botolph's, Boston, Douglas Alfred Langhorne, of Creekside, Bosham, Chichester, to Yvonne Valetta Jessop, younger daughter of the late Mr. and Mrs. Sidney Jessop, of Hathersage.

DEATHS.

ANDREWES.—On February 24th, 1932, at Windy Gap, Merton Lane, Highgate, Sir Frederick William Andrewes, M.D., F.R.S., aged 72.

STIRLING-HAMILTON.—On February 4th, 1932, at Horsham, John Stirling-Hamilton, M.B.E., M.B., B.C.(Cantab.), of Grove Lodge, Ingatestone, Essex, younger son of the late Gen. Sir William Stirling-Hamilton, Bart., R.A.

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